DIVISION OF MEDICAL SERVICES
PROVIDER BULLETIN

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THERAPY/REHABILITATION CENTER BULLETIN

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CASTING/SPLINTING SUPPLY CHANGES

The Division of Medical Services, in order to eliminate paper attachments where possible, will no longer require an invoice of cost for therapy casting/splinting supplies. Procedure codes currently used for casting/splinting supplies (T1999 and 97999) require submission of invoice of cost and will therefore, no longer be effective for services billed on or after November 1, 2005. For all claims submitted on or after November 1, 2005, the following codes shall be used for the casting/splinting supplies:

A4570	Splint	$5.00
A4580	Cast Supplies (e.g. plaster)	$15.00
A4590	Special Cast Material (e.g. fiberglass)	$100.00

For all claims submitted on or after November 1, 2005, the following codes must be submitted for the time spent placing the cast/splint. The allowed amount for the procedures listed below is $10 per unit. Each unit billed equals 15 minutes (i.e. 30 minutes=2 units).

Procedure Code	Description
29049	APPLICATION OF FIGURE EIGHT
29055	APPLICATION OF SHOULDER CAST
29058	APPLICATION OF SHOULDER CAST
29065	APPLICATION OF LONG ARM CAST
29075	APPLICATION OF FOREARM CAST

29085	APPLY HAND/WRIST CAST
29086	APPLY FINGER CAST
29105	APPLY LONG ARM SPLINT
29125	APPLY FOREARM SPLINT
29126	APPLY FOREARM SPLINT
29130	APPLICATION OF FINGER SPLINT
29131	APPLICATION OF FINGER SPLINT
29345	APPLICATION OF LONG LEG CAST
29355	APPLICATION OF LONG LEG CAST
29358	APPLY LONG LEG CAST BRACE
29365	APPLICATION OF LONG LEG CAST
29405	APPLY SHORT LEG CAST
29425	APPLY SHORT LEG CAST
29435	APPLY SHORT LEG CAST
29440	ADDITION OF WALKER TO CAST
29445	APPLY RIGID LEG CAST
29505	APPLICATION, LONG LEG SPLINT
29515	APPLICATION LOWER LEG SPLINT

REMOVAL OF COVERAGE FOR UNLISTED PROCEDURES

Effective for claims submitted on or after November 1, 2005, procedure codes 97039, 97139, and 97799 are no longer active. These unlisted therapy procedures are no longer reimbursed under the Therapy and Rehabilitation Center Programs.

REMOVAL OF DOCUMENTATION SUBMISSION

Effective for claims submitted on or after November 1, 2005, the documentation for intensive therapy (more than 5 units per day or 20 units per week) or more than 16 units of evaluation per year is no longer required to be submitted with the claim. The documentation as outlined in the Therapy Provider Manual or Rehabilitation Center Manual must be kept in the medical record and shall be provided to the Division of Medical Services upon request.

Provider Bulletins are available on the DMS Website at http://www.dss.mo.gov/dms/pages/bulletins.htm. Bulletins will remain on the Published Bulletin site only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin site.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Website at http://dss.missouri.gov/dms/subscribe/MedNewsSubscribe.htm to subscribe to the list serve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896